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ABSTRACT

A workshop aimed to increase participant knowledge about how to improve vocational rehabilitation (VR) services for American Indians with alcohol disorders. Objectives included dissemination of results of a national research project; an overview of issues related to rehabilitation, alcohol abuse, and American Indian people; and specific suggestions for improving rehabilitation services for this population. This proceedings contains five papers and other materials. "Research on American Indians with Alcohol Abuse or Dependency" (Robert M. Schacht) reports on a survey of 31 treatment centers, 90 percent of which were culturally sensitive or used an explicitly Native treatment orientation. "Arizona VR Policies on Serving Clients with Alcohol Abuse or Dependency" (Valerie Lintz) clarifies relevant Arizona policies. "Screening Clients for Alcohol Problems" (Timothy C. Thomason) suggests screening procedures in the initial client interview and outlines features of 10 screening instruments. "American Indian Cultural Issues Regarding Alcohol and Alcoholism" (Candace Shelton) outlines general cultural principles for working with American Indians and discusses appropriate and inappropriate counselor behaviors. "VR Strategies for American Indians with Alcohol or Drug Abuse or Dependency" (Robert M. Schacht) discusses job performance, whether substance abuse or dependency is considered a disability, and specific VR counselor strategies. Appendices contain the Twelve Steps of Alcoholics Anonymous, Arizona VR policies related to substance dependency, a directory of 12 Arizona treatment programs with special services for American Indians, the workshop schedule, recommended readings, and diagnostic criteria for alcohol abuse and dependence. (SV)

ED 432 429

VOCATIONAL REHABILITATION OF AMERICAN INDIANS WITH ALCOHOL DISORDERS

Research Dissemination Workshop Proceedings

November 19, 1997

Phoenix, Arizona

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Edited by:
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PREFACE

The need for studying "the best ways to prevent and treat alcohol and substance abuse problems among American Indians and Alaska Natives" ranked second highest among research priorities in the 1992 American Indian Rehabilitation Research and Training Center (AIRRTC) survey. Dr. Robert Schacht and his research assistants therefore proposed a five-year research project in 1993, "The Vocational Rehabilitation of American Indians who have Alcohol or Substance Abuse Disorders," to identify areas in which vocational rehabilitation counselors need more comprehensive information and training about the rehabilitation of American Indians who have alcoholism or substance abuse disorders, and to identify which vocational rehabilitation strategies work best with this group of consumers. The 1993 research proposal was included in the AIRRTC's competitive grant application for project period 1993-1998. This report represents the research-dissemination of the five-year project. The need to continue to study alcohol and substance abuse problems continues because the 1997 AIRRTC survey from 147 service providers and consumers ranked the need to study "the best ways to prevent alcohol and substance abuse problems among American Indians and Alaska Natives" as the highest priority need to address by AIRRTC researchers.

The AIRRTC at Northern Arizona University has conducted research and training to address rehabilitation services and independent living issues for American Indians with disabilities since 1983. This work has included establishing collaborative working relationships with state rehabilitation agencies, American Indian vocational rehabilitation projects, tribal health and social service programs, and federal services agencies such as the Indian Health Service and the Bureau of Indian Affairs.

The AIRRTC has a broad focus, including identifying the needs of American Indians with disabilities, improving provision of rehabilitation services, and developing labor market analysis models to identify employment opportunities for persons with disabilities residing on reservations. Research and training are conducted at various sites throughout the United States. The AIRRTC provides its research reports, monographs, training curricula, video tapes, and newsletters for people with sensory disabilities in alternative media.

The mission of the AIRRTC is to improve the quality of life for American Indians with disabilities through research and training that (a) result in culturally appropriate and responsive rehabilitation services, (b) facilitate American Indian access to services, and (c) increase the participation of American Indians in the design and delivery of rehabilitation services.

The research-dissemination workshop was co-sponsored by the AIRRTC with the Arizona Rehabilitation Services Administration, Department of Economic Security, State of Arizona. The workshop was funded by the U.S. Department of Education, Office of Special Education and Rehabilitative Services, National Institute on Disability and Rehabilitation Research (NIDRR) and the Arizona Rehabilitation Services Administration, Department of Economic Security, State of Arizona.

AIRRTC faculty and staff members thank the presenters, the Arizona Rehabilitation Services Administration, the workshop participants, the AIRRTC National Advisory Board members, and the supporters of this research project, with a special thanks to Valerie Lintz for her assistance in organizing and facilitating the workshop.

Priscilla Lansing Sanderson

WORKSHOP GOAL AND OBJECTIVES

The main goal of the workshop was to increase participant knowledge about how to improve vocational rehabilitation services for American Indian clients who have alcohol disorders. Objectives included (a) dissemination of the results of a national research project on this subject, (b) an overview of the issues related to rehabilitation, alcohol abuse, and American Indian people, and (c) the specifics of how to improve rehabilitation services for this population.

This research dissemination project incorporated the results of project R-36, "The Vocational Rehabilitation of American Indians with Alcoholism or Substance Abuse Disorders." It condensed the research into a training module and then pilot tested the module. The training module will then be evaluated and revised as needed, and replicated a number of times in several states. It will also be disseminated at "Training of Trainers" workshops at project vocational rehabilitation offices.

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RESEARCH ON AMERICAN INDIANS WITH ALCOHOL ABUSE OR DEPENDENCY

Robert M. Schacht

The former AIRRTC graduate assistant, Lee Gaseoma and I wrote an article based on a survey from about five years ago of vocational rehabilitation counselors; it was published this past year (Schacht & Gaseoma, 1997). That was the beginning of our research efforts in this area. We have continued with some of that research and are now applying it to training.

We knew when we started that the project was not going to be done quickly or easily, so we planned the research in a number of stages. We started with a survey of vocational rehabilitation counselors to find out what they could tell us about what was actually happening. Then we proposed a more thorough research plan for our current five-year funding cycle. We began with a survey of treatment centers that had been recommended to us by the vocational rehabilitation counselors. After the treatment center survey, we did a follow-up survey of vocational rehabilitation counselors using a questionnaire format, and we also conducted some focus groups. Following that, we contacted clients of vocational rehabilitation counselors who had been identified to us as having alcoholism as a primary, secondary, or tertiary disability, and asked them similar questions to what we asked the counselors. One of our objectives was to identify and perhaps help to mitigate particular areas of mis-communication or misunderstanding between clients and counselors. Finally, after surveying treatment centers, counselors, and clients, we made some comparisons and drew conclusions about some differences that we can work on.

Treatment Center Surveys

Weibel-Orlando (1989) compiled a list of the various kinds of treatment models that have been used for American Indians with alcohol abuse or dependency — the Medical Model, the Psychosocial Model, the Assimilative Model, the Culture-Sensitive Model, and the Syncretic Model. At one end of the spectrum was the basically medical model with the most mainstream, Anglo kind of orientation — all anglo staff, very strong Alcoholics Anonymous (AA) orientation, and counselors with university degrees who treat alcoholism as a medical disease. Such an orientation makes little or no cultural accommodation and involves no cooperation with Indian healers. At the other end of the spectrum is the Syncretic Model, which has more of a *native* orientation. In those treatment centers the staff is mostly native, the Alcoholics Anonymous format has been nativized in various ways, or non-AA components have been added to the AA philosophy. The counselors, rather than being all university trained with degrees, are often recovering alcoholics who, at this end of the spectrum, deal with alcoholism as a spiritual disease. These kinds of treatment centers make significant cultural accommodations, which may involve the use of sweat lodges, talking circles, and medicine wheels and other kinds of American Indian components. Often these kinds of treatment centers allow significant involvement with Indian healers.

In 1993 we surveyed treatment centers that our initial set of vocational rehabilitation counselors had identified to us as exemplary. Thirty-one treatment centers responded from 14 states. Based on this information, we sorted them into Weibel-Orlando's range of Treatment Center Types (see Table 1); most of them were towards the "Culture-Sensitive" and "Syncretic" end of the spectrum. Very few had the mainstream Anglo orientation. Almost half of them were operated by a tribe and almost as many were operated by the Indian Health Service. More than half

were on reservations and almost 30% were based in urban areas, so a variety of centers were included.

Table 1 Treatment Centers by Weibel-Orlando Type	
1993 Survey of Exemplary Treatment Centers	
Scope	14 states
Number of Respondents	31 Treatment Centers
Treatment Center Types:	
Medical	0%
Psychosocial	6%
Assimilative	3%
Culture-Sensitive	48%
Syncretic	42%
Operated By:	
IHS	39%
Tribe	45%
Others	16%
Location:	
Reservation	58%
Urban	29%
Others	13%

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Three years later, a number of other questions had arisen about the use of the Alcoholics Anonymous philosophy, so we did a follow-up survey of these centers to find out how they were using the philosophy and the extent to which they may have changed the standard AA approach to accommodate an American Indian's way of looking at things (see "Use of AA Philosophy" section, page 8). So in 1996 we did a follow-up survey of the same 31 treatment centers. We got 14 responses from 9 states. The 31 treatment centers in the original 1993 treatment center survey were using the following main treatment orientations — the Alcoholics Anonymous type of program, generic outpatient treatment programs, outpatient drug-free programs, the 28-day Hazelden or Minnesota model inpatient treatment programs, and Native American traditional healing.

Of those 31 treatment centers, 87% said that treatment of alcoholism or drug abuse was their main service, and 81% said that at least half of their counselors were American Indians or Alaska Natives. Many of these were tribally based programs with at least half of their counselors from one tribe. More than half of them offered both residential treatment and outpatient treatment (55%) and more than half of them had been in operation for more than 12 years (52%).

Stages of Recovery

To determine where the clients of the treatment centers were in their recovery process, we used a stage of client recovery scheme (Prochaska & DiClemente, 1982) that goes from the denial stage, through a contemplation stage ("yeah, there's a problem; I ought to do something about it"), to a preparation stage where they're making definite plans to deal with the problem, to a recovery stage (see Appendix D, Figure 5.1). Most clients came into the treatment centers, not surprisingly, in the contemplation or preparation stages, but some were actually still in the denial stage (see Table 2). Some of these places took court-referred cases and some of the clients

were actually in recovery in some sense—perhaps dealing with relapse issues or other kinds of things.

Table 2
Stages of Client Recovery

Stage	Before Treatment	During Treatment
Denial	+	+
Contemplation	++	+
Preparation	++	++
Recovery	+	++

+ means "some" clients
++ means "the largest number of" clients

Success Rates

We also asked the treatment centers about their success rates (see Table 3). In Table 3, the "Yes" column indicates the percentage and number of treatment centers reporting the overall treatment orientation indicated in the first column. The centers were supposed to check only one of these 12 alternatives, but in fact they checked, on average, 3 to 4 of them. This was totally self-reported and we let them define what they meant by success; we did not try to impose a standard definition of success. The 18 programs reporting the 28-day Hazelden Minnesota model as their dominant treatment philosophy averaged a success rate of 48%. All of the other treatment centers — excluding those 18 — averaged a success rate of 38%. In other words, there is a difference of about 10% between centers that used the Hazelden Minnesota model and those centers that did not. We also calculated a t-test on the significance of the difference between these average success rates, but none of the differences were statistically significant (see Table 3), indicating a lot of variability in

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success rates within each category. Even though the Minnesota model was more successful than the other models, the success rate is still less than 50% (see Table 3).

The highest success rate was from a center that uses the Native American Church as their main treatment strategy. They reported a success rate of 76%, but there is only one of them so that is obviously not a significant basis on which to generalize. Only two places reported an employee assistance outpatient program as their main orientation, and they also recorded high success rates. This looks promising, but again there are not enough examples. Only four reported psychiatric or psychological models, with success rates averaging more than 60%. The more frequently used models all reported success rates in the 40–50% range (see Table 3).

Table 3
Treatment Orientation

"Which of the following best characterizes your overall treatment orientation?"	YES		Mean Success Rate			
	%	N	Yes	No	Difference	t-test*
Native American Church	3.2%	1	76.0	43.5	32.5	
Employee Assistance Program (Outpatient)	6.5%	2	74.5	42.3	32.2	.349
Psychiatric/Psychological Model	12.9%	4	61.5	41.8	19.7	.276
28-Day Hazelden or Minnesota Model Inpatient Treatment Program (Based on AA/NA)	64.5%	18	48.4	37.9	10.5	.370
Native American Traditional Healing	54.8%	15	45.3	43.8	1.5	.891
Spiritual/Religious Program	45.2%	13	44.2	45.1	-.9	.933
Outpatient Treatment Programs (All Types)	64.5%	17	43.4	46.5	-3.1	.784
Outpatient Drug-Free Program	64.5%	13	41.3	47.5	-6.2	.567
AA/NA (Outpatient)	71.0%	20	42.6	49.9	-7.3	.582
Therapeutic Community	6.5%	1	33.0	45.1	-12.1	
Behavioral Approaches (e.g., Aversion Therapy, Behavioral Modification)	19.4%	6	32.7	47.9	-15.2	.193
Methadone Maintenance (Outpatient)	0.0%	0				

*t-test for equality of means, assuming unequal variances.

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Use of AA Philosophy

Because the AA philosophy was used so frequently, we asked those same treatment centers how they were using the AA philosophy, or the extent to which they were committed to using it. Fourteen of the 31 treatment centers responded. Half based most of their treatment methodology on AA (see Table 4). So that leaves another half not or only partially based on AA. Half reported that they nativized the AA treatment philosophy methodology in some way, but there was a great degree of variation as to how they did it. About 30% used sweats and another 21% used various meditations; of course, meditation is one of the AA steps. Fourteen percent used medicine wheels. So although *nativizing* the AA philosophy was quite common, there was no standard way of doing it. Most of the treatment centers required AA attendance as part of the treatment, averaging about six AA meetings per month (see Table 4). Most of them required or recommended continued attendance at AA meetings after therapy ended.

When asked whether cultural differences were significant barriers for client participation in AA, most said that they were not (see Table 4). Probably the most common cultural barrier discussed was whether it is okay to discuss personal problems in public, so to speak, at AA meetings, which is sometimes cited in the literature as a problem for American Indian clients. About half of the treatment centers said that was a problem for their clients.

Next, there have been some reports in the literature that some people considered AA too religious. That was not a problem with the treatment centers in this survey—most reported that AA meetings were *not* too religious (see Table 4). The issue is not whether AA is spiritual or not; the issue is whether AA, as it is practiced by some local groups, is too *Christian*. I don't think American Indians

Table 4
1996 Treatment Center Follow-up Study: Use of AA Philosophy in Treatment
(N = 14)

• Most of their treatment methodology was "based on" AA	50%
• Used a "Nativized" treatment methodology, such as Sweats (29%), Meditation (21%), or a Medicine Wheel (14%)	50%
• Most required attendance at AA meetings as part of treatment (mean frequency was six AA meetings per month)	71%
• Attendance at AA meetings always part of recommended aftercare	86%
• Cultural differences not a barrier for client participation in AA	64%
• Public discussion of personal problems a barrier for clients	50%
• AA meetings are not too religious	86%
• Most important of AA 12 Steps: Step One ("We admitted we were powerless over alcohol—that our lives had become unmanageable.")	50%
• Used first 4 AA Steps	100%
• Used all 12 AA Steps	64%

have a problem with the spiritual component of AA, but sometimes American Indians have a problem with specific Christian concepts that some AA groups use. However, that's very tentative.

When asked to rank the importance of each of the AA Twelve Steps (see Appendix A), treatment centers ranked the First and Second Steps as most important. All 14 of the treatment centers used the first four steps of AA as part of their treatment strategy, and most of them actually used all of the Twelve Steps. The issue is partly one of time; most treatment programs have clients for a limited amount of time. Of course, the AA philosophy is self-driven, so there is a limit to

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how fast clients can move through the Twelve Steps. Many have found that they can usually work through the first four steps of AA in the time available, but then for the other eight steps they have to rely on after-therapy, such as attendance at AA meetings. So that is how these centers were using the AA philosophy

Comparison Between Counselor and Client Surveys

The 32 VR counselors surveyed were not necessarily counselors of the clients who were surveyed, but the distribution by states is similar. In fact, every client questionnaire came from a state from which we also obtained at least two counselor questionnaires. We received at least two client questionnaires and at least two counselor questionnaires from five states: Arizona, New Mexico, Texas, South Dakota, and Minnesota.

All of the clients interviewed (24) were candidates for the VR system, making them a unique population in comparison to the general pool of candidates who have an alcohol or drug problem. In addition, most of these clients became *eligible* for VR services. Thus, it is a biased sample. For example, the Rehabilitation Act requires both that alcoholic clients have a recognized disability due to alcoholism, and that they be in recovery. Thus, these clients are less likely to be in denial than alcoholics in general. Also, as the most prevalent recovery method is Alcoholics Anonymous, respondents in this sample are probably more likely to be familiar with AA and approve of it.

One difference between the two groups was that only 29% of the clients thought that American Indians were as successful in becoming eligible for VR services as non-American Indians. Most (54%) did not know if there was a difference in the eligibility rate. However, most of the VR counselors (63%) believed that American Indian clients are as successful in becoming eligible as non-Indian clients.

With regard to barriers to successful vocational rehabilitation, clients and counselors both listed transportation as the main deterrent (see Table 5). The second biggest problem listed by both clients (46%) and counselors (56%) was "lack of follow-up by the client." Perceptions of barriers to success differed most strongly with respect to the counselor's perceived judgment that the client wouldn't benefit from services — the clients thought this was true much more often than the counselors.

Table 6 compares the clients' evaluation of drinking styles and behavioral influences with the counselors' assessment of the same factors. The two largest disparities fall between the difference between the means for the "social drinking" category and the "solitary drinking category." In brief, the vocational rehabilitation counselors rate their clients' drinking problems much higher than the clients do, and they underestimate the amount of significant stress and relationship problems that clients experience.

Table 5 Barriers to Successful Rehabilitation			
Problems	**Percent of Clients**	**Percent of Counselors**	**Difference**
Counselor's Judgment that Client Will NOT Benefit from Services	42%	9%	33
Lack of Follow-up by Counselor	42%	25%	17
Lack of Counselor-Client Rapport	38%	21%	17
Concern for Confidentiality	25%	18%	7
Discrimination/Cultural Insensitivity	25%	25%	0
Lack of Transportation	54%	62%	-8
Cultural Differences	42%	50%	-8
Lack of Follow-up by Client	46%	56%	-10
Confusion about Eligibility Criteria	29%	40%	-11
Process Taking too Long	38%	46%	-12
Lack of Trust	21%	47%	-26

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Table 6
The Difference Between Means for Clients and Counselors

	Mean* (Clients)	Mean* (Counselors)	Difference between the Means
Significant Stress	4.08	3.44	.64
Difficult Relationships	3.70	3.53	.17
Binge Drinking or Drug Abuse	3.04	3.52	-.48
Social Drinking	2.65	3.63	-.98
Solitary Drinking	2.43	3.23	-.80

*Note: Scale: 1 = No/Never; 5 = Very Often

Table 7 shows substantial differences in client beliefs and counselor perceptions about those beliefs. For example, the clients showed a much higher awareness that "alcohol was more trouble than it's worth" than counselors perceived. They were also more optimistic about their ability to get help in treatment than the counselors thought they were, and were more ready to get into treatment than counselors thought they were.

On the other hand, counselors were much more likely to think treatment was too demanding than the clients themselves. The most accurate counselor perception of client beliefs was about the influence of alcohol abuse on keeping a job.

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Table 7
Beliefs about Alcohol and Drugs

	Mean* (Clients)	Mean* (Counselors)	Difference between the means
Alcohol was more trouble than it's worth	4.57	3.36	1.21
Can get help in treatment	4.33	3.19	1.14
Wanted to enter treatment	4.39	3.41	.98
Alcohol would cause death if you did not quit	4.17	3.22	.95
Felt a need to be in treatment	4.09	3.22	.87
Life was out of control while drinking	4.50	3.68	.82
Alcohol made life worse and worse	4.58	3.78	.80
Tired of the problems	4.43	3.69	.74
Felt an urgent need for help	4.17	3.52	.65
Wanted to get life straightened out	4.67	4.03	.64
Needed help to cope with alcohol use	4.52	3.88	.64
Alcohol caused problems with work	4.39	3 88	.51
Alcohol caused problems with the law	4.39	3.94	.45
Alcohol caused problems with family	4.61	4.19	.42
Alcohol was a problem	4.42	4.03	.39
Alcohol caused problems keeping a job	3.61	3.87	-.26
Treatment has not been very useful	2.45	2.80	-.35
Treatment program staff can't be trusted	2.61	2.97	-.36
Had too many responsibilities to be in treatment	2.43	2.94	-.51
Treatment was too demanding	1.62	3.22	-1.60

*Note: Scale: 1 = Strongly Disagree; 5 = Strongly Agree

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Other Recent Research

In a Native American–based cultural model of substance dependency and recovery developed by Watts and Cuttieres (1997), 58 clients were interviewed at three residential facilities in Phoenix. All three treatment facilities used the AA 12-Step philosophy. Fifty-one percent of the clients were born on reservations. Fifteen tribes were represented, with most clients (60-70%) describing themselves as "traditional."

Watts and Guttieres (1997) did not claim that their cultural model works for all Native Americans. But since it was based on clients from 15 tribes, it is multi-tribal. Their cultural model encompasses a four-stage process of rehabilitation:

1. Experiences leading an individual into substance dependency may include a view of alcohol as an agent or 'spirit' that can take control, a perception of dependency as taking the wrong path, or the idea that addicts are made, not born.

2. "Coming to terms" with substance dependency can mean "letting in" the support and mediation of trusted elders and friends who practice what they preach, and who provide positive role models.

3. Recovery includes regaining personal autonomy and control over the substance via abstinence and spiritual healing; the Red Road metaphor can help.

4. Successful maintenance requires integrating the knowledge gained from one's experience into daily life and becoming a positive role model for others.

In other recent research, a study by Spicer (1977) based on field work with 35 self-identified American Indian alcoholics in the Minneapolis–St. Paul area, concluded that these drinkers see their drinking as something that is embedded in important relationship patterns, but also as something that is destructive of much of what they value. Thus, they were acutely aware of the problems caused by their drinking, but felt that they could not give up the relationships which enabled and encouraged it.

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2

ARIZONA VR POLICIES ON SERVING CLIENTS WITH ALCOHOL ABUSE OR DEPENDENCY

Valerie Lintz

Clarification of certain Arizona vocational rehabilitation policy issues, as of November 1997, with regard to substance abuse, employment, and restoration services can help counselors provide appropriate vocational rehabilitation services. Impairment must be documented by a licensed professional (see Appendix B).

To establish chemical dependence, a diagnostic statement must be provided by (a) a physician skilled in the diagnosis and treatment of mental or emotional disorders (psychiatrist) who is licensed by the appropriate state; (b) a psychologist licensed or certified by the appropriate state; or (c) a substance abuse counselor certified by the Arizona Board of Behavioral Health Examiners.

Whether or not someone is abusing drugs or alcohol is relevant to determining whether the individual can benefit from VR services in terms of an employment outcome. A client is assumed to be able to benefit unless there is clear and convincing evidence to the contrary. It is the responsibility of the counselor to use extended evaluation services if necessary to determine "ability to benefit" if there is a strong indication that the individual is abusing drugs or alcohol to an extent that vocational success is impossible or unlikely.

A diagnosis of "substance abuse" alone cannot be used to determine vocational rehabilitation eligibility. Arbitrary periods of sobriety likewise cannot be used as general standards for making the required individualized vocational rehabilitation eligibility determinations.

To determine that an individual is "substance dependent" means that the individual meets the criteria described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). That definition describes a maladaptive pattern of substance use (see Appendix B).

The report used to describe "substance dependency" for eligibility purposes must include descriptive statements that illustrate the pattern of substance use and substance dependency (per the criteria in the DSM-IV) upon which the diagnosis is based. The report must also include information regarding the history of treatment and current treatment.

Counselors are expected to make every attempt to obtain existing documentation of substance dependency. When requesting existing documentation or purchasing documentation, the counselor must send to the vendor the Vendor Request for Documentation of "Substance Dependence" (Arizona form: VR-019), which explains the type of documentation needed for eligibility (see Appendix B). When requesting an existing document, the appropriate client release of information form must also be enclosed.

Individuals who have marketable skills in occupations that pose no immediate and direct threat to continued sobriety and who require no other services would not normally be considered eligible for vocational rehabilitation services. "Stress on the job" or "the job drives me to drink" are not unconditionally appropriate reasons for abandoning established work skills.

Individuals with marketable skills may, however, require vocational counseling, job development and placement assistance, and other services related to their disability and resultant unemployment. Such individuals would be eligible for vocational rehabilitation services but would not have access to training or education services.

Detoxification is considered an acute medical service and is therefore not provided by Rehabilitation Services Administration. Alcohol or drug abuse maintenance programs are also not provided by vocational rehabilitation; they are considered medical care services. Individuals are not eligible for vocational rehabilitation based solely on the need for these services.

Mental health treatment means treatment of mental or psychological conditions through individual, family, or group therapy. Services include social work services, substance abuse counseling, and mental health or substance abuse counseling.

3

SCREENING CLIENTS FOR ALCOHOL PROBLEMS

Timothy C. Thomason

There are an estimated 10 million alcoholics in the United States and another eight million alcohol abusers (Brizer, 1996). Less than 15% of these people ever receive any treatment. Because it is such a common problem, and because it can sabotage treatment for any other problems if not addressed, every client should be screened for alcohol problems in the initial interview. Screening need not take more than two or three minutes.

The accuracy of screening depends on several factors: the client's sobriety, comfort level, and motivation, the perceived attitude of the interviewer, the presence or absence of other people, and cultural norms. Validity is enhanced by establishing an atmosphere of trust, safety, and confidentiality.

The *Handbook of Alcoholism Treatment Approaches* provides an overview of screening and guidelines for screening and treatment (Hester & Miller, 1995). Suggestions for increasing the likelihood of an accurate screening include the following: (a) Do not screen a client who is intoxicated; do it later when the person is sober. (b) Tell the client that the purpose of the screening is to assess the impact of drinking on the client's health. (c) Avoid use of the terms "alcoholism," "addiction," and other disease labels; instead, focus on the potential health risks of excessive drinking. (d) Consider using paper-and-pencil questionnaires if the client seems intimidated by the face-to-face interview.

Screening methods are not perfect; for example, clients can simply lie about or minimize their alcohol usage. In addition, because screening tests are designed to be as sensitive as possible; false positive results are common. Positive results on a

screening test should always be followed with a diagnostic assessment. A client cannot be diagnosed with an alcohol problem on the basis of a screening test. Also, because most of the research on screening tests has been with white males, they may be less useful with other populations.

After the screening, if the client seems likely to have an alcohol problem and wishes to address it, refer the client for a thorough assessment. The purpose of the assessment is to establish a diagnosis and develop a specific treatment plan. Many clients never follow up on a referral. According to some studies only 10% to 30% actually enter treatment (e.g., Cooney, Zweben, & Fleming, 1995).

To enhance clients' motivation for change, ask about their own understanding of their alcohol usage and discuss the potential consequences of continuing to drink. Describe the various options, including self-change, attending support groups, and formal treatment. If a client claims to be able to control their drinking, suggest that the client not drink for a week or two as an experiment. Inability to abstain suggests the existence of a problem. This discussion should occur in a supportive and non-confrontational manner. Take a neutral stance in discussing the data and never argue with a client. Use conversational techniques such as summarizing, clarifying, and reflective listening. Check repeatedly for the client's understanding, and ask the client to express their concerns.

If the client is willing to examine his/her drinking behavior, discuss the alternatives. One option is to do nothing (but there are consequences that you can discuss), normalize the ambivalence and uncertainty the client probably feels, and emphasize that the client has total control over deciding what action to take.

If the client is strongly resistant, do not make a referral. Suggest that the client might want to take some time to think about treatment and maybe talk to significant others before making a decision. Be sure the client knows who to contact

if he/she decides to seek an alcohol assessment or treatment and give the client a list of community resources for future reference.

Quick Screening Instruments

Michigan Alcoholism Screening Test (MAST)

- Paper-and-pencil test with 25 questions requiring yes or no answers.
- Designed to detect alcoholism.
- Meant to be administered orally by the interviewer; can also be completed by the client, although this may affect its validity.
- No data on reliability.
- Does not control for faking, so may not be effective with people who are trying to minimize their alcohol use.
- For more information, see Appendix D and Selzer, 1971.

CAGE Questionnaire

Four questions to screen for alcohol abuse:

C Have you ever felt you should Cut down on your drinking?

A Have people Annoyed you by criticizing your drinking?

G Have you ever felt bad or Guilty about your drinking?

E Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

- Useful for initial screening when time is a factor.
- Positive responses to any two of the four questions indicate possible alcohol abuse and the need for more detailed assessment.
- Does not control for faking, so may not be effective with people who are trying to minimize or deny their alcohol use.
- For more information, see Mayfield, et al., 1974.

TWEAK Questionnaire

This is a modification of the CAGE, to screen for alcohol problems in women.

T How many drinks can you hold? (3+ drinks suggests Tolerance)

W Have close friends or relatives Worried or complained about your drinking in the past year?

E Do you sometimes take a drink in the morning when you first get up? (Eye-opener)

A Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (Amnesia or blackouts)

K Do you sometimes feel the need to K/cut down on your drinking?

A large research study found that these five items were more sensitive than the CAGE or the MAST to screen for alcohol abuse in a population of 4,000 primarily inner-city African American women (Russell, et al., 1991).

Substance Use Disorders Diagnostic Schedule (SUDDS-IV)

- 45 questions, self-report, paper-and-pencil.
- To assess use of alcohol and drugs (including tobacco).
- Includes questions on stress, anxiety, depression.
- Introductory Kit $21.00.

Triage Assessment for Addictive Disorders (TAAD)

- 31 questions, self-report, paper-and-pencil.
- Designed to assess use of alcohol and drugs.
- Includes questions sufficient to make a DSM-IV diagnosis.
- Introductory Kit $22.00.

The SUDDS-IV and TAAD are available from New Standards, Inc., 1080 Montreal Avenue, Suite 300, St. Paul, Minnesota, 55116.

Comprehensive Screening Instruments

Addiction Severity Index (ASI)

- The ASI is the most widely used substance abuse evaluation instrument in the world; research has shown it to be reliable and valid.
- Designed as an outcomes research and treatment planning tool.
- Assesses seven areas related to addiction and relapse: alcohol and drug use, employment, medical, legal, psychiatric, family and social problems.
- Scores indicate the client's need for treatment in each area.
- Usually administered at the start of treatment, at discharge, and at six months post- discharge.
- Administered in an interview by a trained technician; does not require clinical staff.
- Requires training to conduct the interviews.
- The interview requires 45 to 60 minutes; shorter versions are available.
- The test results are useful for treatment referral and planning.
- Norms are available for several populations.
- Generic orientation, not based on any one theory of addiction or treatment.
- Available in English and nine foreign languages.
- For more information see McLellan, et al., 1992 and Sperry, et al., 1996.

Substance Abuse Subtle Screening Inventory (SASSI)

- Probably the second-most used inventory after the ASI.
- Paper-and-pencil questionnaire, 88 items, takes 15 minutes.

- Includes items on alcohol and drug use patterns, and emotional, interpersonal, cognitive, social, and psychological domains.
- Designed as a screening and treatment planning instrument.
- Less studied than the ASI, but the developers claim 90% classification accuracy; claims to discriminate substance abusers from non abusers despite denial or minimization efforts by abusers.
- Norms are available. For more information see Miller, 1985.

McAndrews Scale of the Minnesota Multiphasic Personality Inventory (MMPI)

- Designed to detect alcohol problems.
- Provides accurate results with clients who honestly answer the questions.
- Includes items to detect faking.

Instrument for Native Americans

Alcoholic Dependency Behavior Inventory (ADBI)

- Designed for screening and treatment planning.
- Meant to distinguish Native American alcoholics from non-alcoholics.
- Shown to be more effective than the MMPI for this population.
- Paper-and-pencil, self-report, 36 questions.
- For more information see Peniston & Burns, 1980.

Contact: Dr. Eugene Peniston, Redfield State Hospital and School, P.O. Box 410, Redfield, SD, 57469.

Instrument for Multicultural Populations

Alcohol Use Disorders Identification Test (AUDIT)

- Designed for early identification of problem drinkers.
- Effective in discriminating high-risk drinkers in six countries.

- Ten questions that can be asked in an interview or administered as a questionnaire.
- For more information see Barbor, et al., 1992.

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4

AMERICAN INDIAN CULTURAL ISSUES REGARDING ALCOHOL AND ALCOHOLISM

Candace Shelton

I want to emphasize diversity. Although there must be some very general ways of looking at people who are Native American, what's really important to remember is that there are 532 distinct entities or tribes of Native Americans, some heavily recognized and some not, and they're all very different. It is important to realize that tribes are very different, and the people that make up those tribes are very different.

I'm the Clinical Director at Guiding Star Lodge, which is an alcohol and drug treatment center for Native American women, where they can bring their children. One of the biggest barriers to alcohol and drug treatment for women is what to do with your children. In Indian country that's an even bigger barrier because many times there is no safe place to leave the children. So many women don't come to treatment because they don't want to leave their children. The Guiding Star program allows children to be with their mothers during treatment. Our policy is to allow only two kids, but we've been flexible enough to allow anywhere up to six. One woman had no place to leave her kids, so we took all six children. We have a little bit of difficulty with that, because it's real hard for a mother to concentrate on treatment when she's trying to take care of her kids. That's a full-time job anyway, and then doing that while on treatment is pretty tough. The mother is in treatment during the day from 8 a.m. to 5 p.m.

We also have a preschool and a nursery at the Guiding Star Lodge. The older kids go to school; there's a school very close to us that is willing to take our kids

because it's only for 60 days. We have a full-time master's level child therapist, so the kids themselves participate in counseling sessions. Many of the kids that accompany their mothers have already experimented with and are using some substance on a consistent basis, either alcohol or drugs, so we do some intervention with them while they are in treatment. We have a mom who is 8 1/2 months pregnant right now. She will give birth while she is here with us and will stay for an additional 60 days. We have all ages from newborns up to 13, but we are not an adolescent center; that's a whole other area. We do have a 14-year-old girl at the moment, but there was no place else for her to go. As a result, although we have rules, we wind up breaking them as a necessity.

Speaking of diversity, we currently have 22 women in treatment from 18 tribes, and there are differences in how they interact. For example, I do some consulting work, and I have done a lot of traveling around Indian Country, in the United States and Canada as well. With the groups I have held, say, here in the Southwest, you have to work hard to have some interaction. They're very quiet. They want to observe. That's wonderful—especially in a new kind of a group or a workshop. I have done that same workshop in Canada with the Mohawks, and I can't get them to be quiet. They just talk, talk, and talk and ask questions, and are very interactive. So very different counseling strategies are needed. Be aware of those differences. Working with a Navajo may be different from working with someone who is a Mohawk. Even among the big tribes in our state, which would be Navajo, Hopi, Yaqui, and Pima, there are differences. It is important to remember that they are all Native Americans, but they have different lifestyles and different traditions.

American Indians are not a homogeneous group, as there are vast variations in cultural beliefs, traditions, and lifestyles. Many factors may influence the beliefs of an American Indian, including a subtribe or clan affiliation, tribal sociality or membership, level and type of formal education, influence of outside religion,

marriage, and length of time spent off the reservation. Some Indians may not know the traditional beliefs and may not identify with them. One cannot generalize across individual, tribe, or group, but the literature does point out several general themes when working with traditional American Indian society that differentiate it from Anglo society. The following are examples:

Religion	
American Indian	Anglo
• A way of life	• Observed at special occasion
• Interwoven with beliefs about health, social values and family	• Separate from other values and beliefs

Ambition and Work Orientation	
American Indian	Anglo
• Work periodically to meet immediate needs	• Work steadily for immediate future rewards
• Family and religious values take precedence over work	• Work is equal to or supersedes family and religious beliefs
• Not material oriented	• Material oriented

Some Ideas About Working with American Indians

1. Familiarize yourself with the client's culture through the voluminous amount of existing literature, Indian centers, university facilities, and tribal units.

2. Your client's actions are expressions of his belief system. Be able to assess your client's level of acculturation to assist in understanding his behavior, as well as in selecting appropriate intervention strategies. Clues to help determine the level of

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acculturation can be found in (a) language, (b) use of English versus Indian names, (c) preservation of linkages to extended family, (d) the number of trips to visit extended family on the reservation, (e) time orientation, (f) religion, (g) food preferences, (h) the level of participation in traditional social or tribal activities, and (i) education (e.g., emphasis placed on traditional teachings). More acculturated Indians will seek out and respond positively to mainstream treatment facilities and approaches. More traditional Indians will avoid becoming involved in treatment as long as possible. They are inclined to seek out more traditional methods such as consulting a medicine man or an elder in the family, or ceremonies.

3. Do not assume that Euro-American theories of counseling and psychotherapy are applicable to more traditional American Indians. For example, does Carl Rogers's view of self-actualization fit a culture that emphasizes cooperation and harmony over individual achievement? Or does Adler's psychological model, which emphasizes family systems and birth position, fit individuals raised in an extended family and clan system?

4. Understanding and being tolerant of another person's culture is not sufficient; the caregiver must understand how his or her own behavior either impedes or facilitates the communication and recovery process. The following brief vignette is provided to illustrate potentially inappropriate interpersonal and social behavior based on traditional Western Apache beliefs:

> [A caseworker takes John, a 40-year-old Western Apache patient, to meet his therapist and group]. "Frank [the caseworker], I'd like you to meet John T., your new patient." [Frank, the therapist, says] "John, it is nice to meet you." [While speaking, Frank simultaneously takes John's hand and shakes it, while looking him directly in the eye, then states] "I'd like to have you come in and meet the rest of the group" [again, while speaking

Frank touches John's shoulder slightly as he orients him into his office, and then states] "Group, I'd like you all to meet John T., a new patient, and John, my friend, I'd like to have the rest of the group introduce themselves." [During this process several group members address John by using his first name. As the group commences, Frank states] "John, I wonder how you are feeling about being in treatment? Is there anything I or the rest of the group could do to make you feel more comfortable?" [After a significant amount of group interaction occurs, Frank says] "John, I notice your chair is pushed back slightly and you have been quiet. Is there something going on with you?" [After a few seconds, Frank restates the question by saying] "I'm concerned that you might not feel comfortable yet, but that's pretty normal."

What is wrong in the above picture?

a. *Frequent use of the first name.* Some American Indians classify personal names as items of individually owned property. Using one's first name is likened to temporarily borrowing a valued possession. The rights of such borrowing are earned through friendship, trust, good will, and solidarity developed over time. Even among Western Apaches who are good friends, name avoidance is the rule, not an exception. Overuse of first names is considered an exploitation that violates one's rights, and it is characterized as obsequious behavior. When joking privately, Western Apaches say, "these white men must be forgetful."

b. *Shaking hands, touching, and guiding toward office.* Western Apaches, particularly adult males, are careful to avoid touching in public, as it is viewed as a direct encroachment upon the private territory of self. Touching without apparent reason suggests homosexual overtones and is grounds for suspicion. Even mild

physical orientation toward an area or location is an open violation of one's right to freedom of movement.

c. *Eye contact.* Direct eye contact, particularly at close quarters, is typically viewed as an act of challenge, defiance, or aggression.

d. *Introduction to group.* This behavior is the equivalent of saying, "Look who's here, everybody." When a Western Apache joins or leaves a social grouping, she or he prefers to be unobtrusive. Being singled out results in embarrassment, isolation, and being socially exposed.

e. *Addressing one as "my friend."* There is no Western Apache word that corresponds to the English word "friend." The nearest equivalent is *shich'inzhone,* which translates into "toward me, he is good." This word is used only by individuals who have known each other for many years, and on the basis of their experience have developed strong feelings of mutual confidence and respect. The use of this phrase by a stranger may be seen as not genuine and presumptuous.

f. *Asking, "How are you feeling?* Is there something going on with you?" Except among persons who enjoy very close relationships, such as a husband and wife, unsolicited queries concerning an individual's health or emotional state are considered impertinent violations of personal privacy. If a Western Apache decided to discuss such matters, he would do so on his own accord, or else it is nobody's business. This is viewed as a form of self-indulgence, prying behavior, and poor self-control. In joking, this is equated with the babbling of babies or the ramblings of senile people.

g. *Repetition of questions or statements.* It is considered rude to repeat a question more than once or twice. It is extremely discourteous to request or demand a reply. These behaviors create an atmosphere of urgency, verbal coercion, and strong-arming.

h. *Asking "rapid-fire" questions* (not allowing for a latent period between questions or a question and answer). Western Apaches consider it an obvious and important truth that carefully considered replies to questions are more accurate and reliable. Such replies are less likely to be retracted or modified than rushed replies.

i. *Advice and directives.* Western Apaches usually avoid verbal directives and ordering, or construct them in more oblique ways that carry the force of observations (e.g., suggesting that "there are lots of mosquitoes today," instead of "take your jacket when you go hunting").

j. *Paralinguistic factors.* Western Apaches address each other in low, softly modulated tones at a pace they consider measured and deliberate. They do not respond well to loud, rapid-paced, and high-pitched voices. They have labeled such speech patterns as "too fast," "too loud," and "too tense." Some Western Apaches have observed that white men "are angry even when they are friendly." The Anglo speech pattern is oftentimes viewed as an expression of criticism, indignation, and scolding.

5. Do not expect verbal feedback. "We will not tell you how good you are doing, but will speak of it when you are gone" and "we may not tell you, but we may not forget it if you hurt our feelings" are two behaviors identified by a committee of Navajos who put together a list of traits from traditional culture. Many Indian people are reluctant to provide direct feedback, which should not be construed as their not having developed unique perceptions and reactions to others. Their nodding does not mean that there is understanding or agreement, it reflects polite listening. Studies have shown that American Indians prefer much longer observation, processing, synthesis, and incubation time.

6. Quiet behavior in a group may have several explanations: (a) The Indian patient may be reluctant to talk because of poor expressive English skills and a fear of ridicule. (b) S/he may identify with the traditional learning and belief that talking

in a group draws attention to self, which is undesirable. (c) S/he may have a limited understanding of the process or what is being expected, due to language and cultural differences. (d) S/he may have learned that when an Indian person goes to an elder for help (counseling), the elder may talk for an hour while the client listens. Out of respect the Indian is listening for the message before s/he speaks. (e) The Indian desires more time to assimilate information before responding.

7. Tailor your approach to be consistent with cognitive style. (a) Pace and "wait time." Go slow, allow plenty of time for assimilation. Wait for responses to your questions before asking another question. After getting a response, take time to process and assimilate the information before responding or asking another question. Expose new ideas slowly and allow the patient to set the pace and control the process. (b) Be visual, descriptive, and holistic. Use visual modalities to demonstrate concepts and points (e.g., charts, graphs, pictures, drawings, demonstration, etc.). Proceed from the general to the specific (Gestalt); do not segment. Do not be overly analytical.

5

VR STRATEGIES FOR AMERICAN INDIANS WITH ALCOHOL OR DRUG ABUSE OR DEPENDENCY

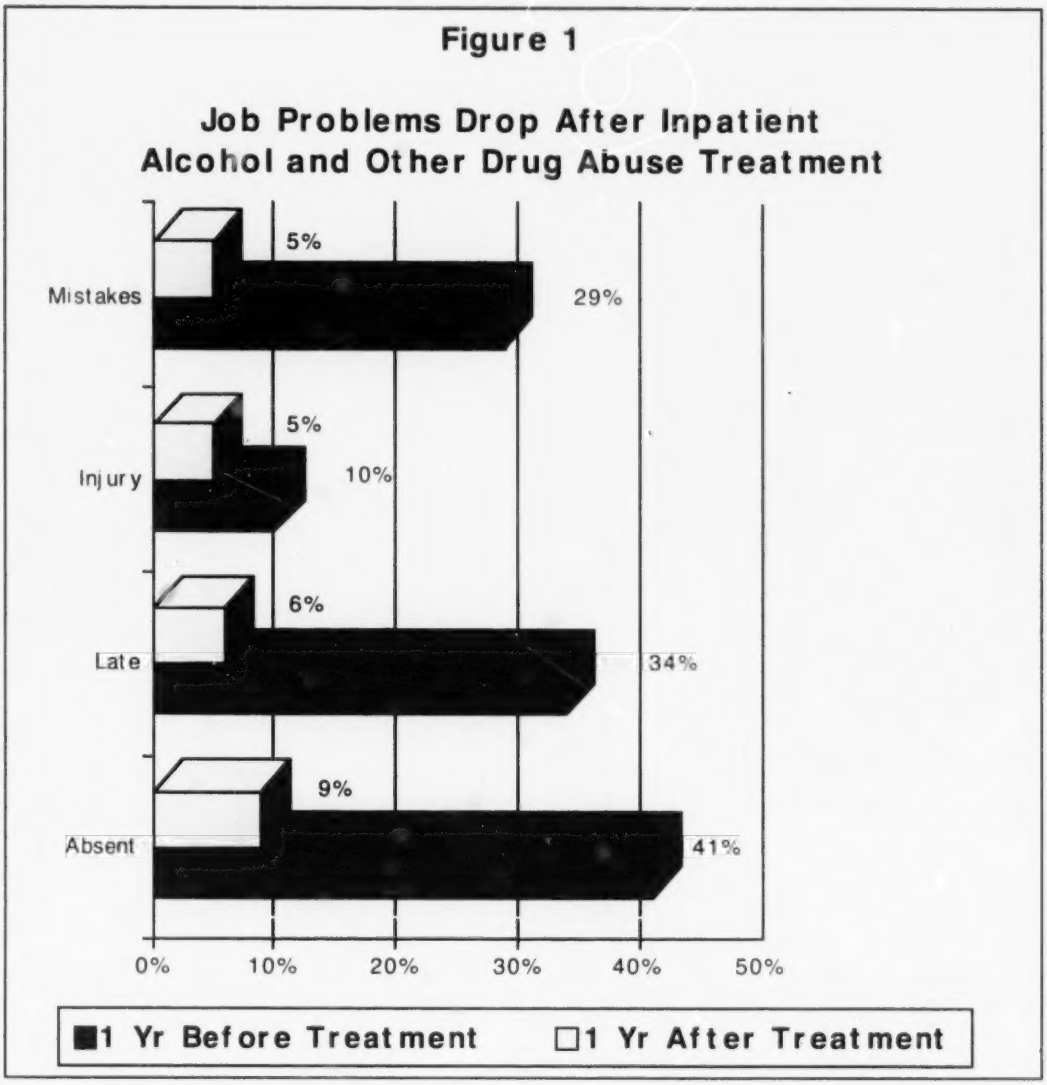
Robert M. Schacht

Before considering vocational rehabilitation with American Indians who have alcoholism or drug abuse dependency, I'd like to review several preliminary matters. According to statistics from the Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.), treatment for addictive disorders enhances performance on the job and elsewhere. An estimated 59% of adults who reported using an illicit drug during the past month were employed (preliminary estimates, NHSDA, SAMHSA, 1993). After treatment for alcoholism, 90% of participants in one study consistently received satisfactory job performance ratings (Wright, Grodin, & Harig, 1990). There was a 20% reduction of accidents on the job following intervention by an employee assistance program (Yandrick, 1992). These improvements are depicted in Figure 1.

The *Diagnostic and Statistical Manual of Mental Disorders* defines *alcohol dependence* as a maladaptive pattern of alcohol use, leading to clinically significant impairment or distress as manifested by three or more of the following items: increasing tolerance for alcohol, withdrawal syndrome, inability to control drinking, important activities neglected because of drinking, excessive time spent drinking and recovering, or drinking despite knowledge of problems due to consumption.

Alcohol abuse includes some impairment and stress due to similar factors, but falls short of alcohol dependence. These distinctions may be important in establishing disability. For example, in your state, *alcohol dependence* may be a disability, but not *alcohol abuse*.

Figure 1



Harrison and Hoffman, 1989.

The VR system recognizes alcoholism and substance abuse as disabilities in the sense that disability codes are defined for them (520, 521). However, the Rehabilitation Act of 1992 [29 USC 706(8) as amended] devotes special attention to alcoholism and drug abuse, with respect to eligibility for services.

An alcoholic who is not abstinent so that the alcoholism constitutes a substantial impediment to employment seems for exactly that reason to be excluded from the definition of an "individual with a disability," which excludes "any individual who is an alcoholic whose *current use* of alcohol prevents such individual from performing the duties of the job in question" [subparagraph (C)(v) as amended; emphasis added].

However, the term "individual with a disability" includes not only those for whom alcoholism is a limiting impairment, but also those with a record of such an impairment or those regarded as having such an impairment (subparagraph B), (ii) and (iii). In other words, it would seem that the only clients of this sort who might be eligible for VR services are abstinent alcoholics who have a record of alcoholism or are regarded as alcoholics, and for those reasons find it difficult to get or keep a job.

Another possibility is created by subparagraph (C)(ii): Alcoholics or drug users for whom substance abuse has been a substantial impediment to employment (e.g., they were fired from their last job for this reason) who are participating in or have successfully completed a supervised drug rehabilitation program, but have not yet been able to find employment. This would appear to be the primary target population for persons with this disability.

Things a VR Counselor Can Do

Recognize Problem Drinking as Defined by Native Americans

Native Americans may have a different set of ideas about what constitutes problem drinking than you do. Among Native Americans, problem drinking tends to be defined in respect to the social group rather than in terms of individual clinical markers or negative consequences for the individual. Thus, medical sequelae, accidents, suicides, or homicides tend to be mentioned less often than the following: drinking heavily and overtly at urban pow wows, drinking at the drum or dancing while intoxicated at an urban or rural pow wow, the regular appearance of community leaders drinking in low-status bars, asking direct and personal questions while under the influence of alcohol, drinking alone, not eating during a drinking session, drinking wine rather than beer or hard liquor, drinking at serious business events (community meetings), drinking in areas designated as sacred space, making uninvited sexual overtures while under the influence of alcohol, drinking while participating in athletic contests, not being able to defend oneself in a fight because of one's level of intoxication, or not providing adequate financial support for one's family due to drinking costs (Weibel, 1982, summarized in Kinney, 1989).

For VR counselors who need to establish agreement with their client that drinking is a problem, it may therefore be better to start with identifying behaviors such as these before dwelling on behaviors that may be destructive to the individual alone. It is even better if the counselor can get the *client* to express verbally his or her own concerns about drinking and its effects, to state their perceptions that drinking is a problem. This strategy is part of one of the five general principles underlying motivational interviewing (Miller, 1995), and might not be as difficult as one might think. According to a recent study by Spicer (1997), American Indians are often acutely aware of the problems their drinking can cause, including how their

drinking prevents them from keeping jobs (p. 315). Spicer's findings confirmed the point above that "the ability to keep a job and to support or at least contribute to one's family were understood as marks of a mature man, and men who continued to drink saw themselves as failures in their communities and as weak or nonexistent members of their families." If American Indian clients who are alcoholics can be encouraged to voice their own concerns about the problems their drinking has caused, they are more likely to see the dissonance between the effects of these problem behaviors and their own important personal goals. They are then more likely to become more willing to change. In motivational interviewing, this is called *developing discrepancy* (Miller, 1995, p. 96).

Support Abstinence

The process of recovery is often fragile, and yet the process of eligibility determination, developing an Individualized Written Rehabilitation Plan (IWRP), and initiating services can seem like an eternity to clients who are alcoholics and often live almost totally in the *now*.

Most clients, especially American Indian clients who are alcoholics, have difficulty understanding why the eligibility process sometimes takes as long as it does. Counselor-client contact during this process, along with explanations about the process, can help prevent a client from feeling abandoned and can help convey a "we care" message.

In this process, it can be important to show empathy (à la Carl Rogers) rather than confrontation. The Rogerian skill of reflective listening is used extensively to help clarify ambivalence without eliciting resistance. This seems paradoxical — communicating acceptance of clients as they are, they feel more free to change. Expressing empathy is one of the five general principles underlying motivational interviewing (Miller, 1995, p. 96).

Referral to Treatment Centers

If a client is not abstinent, or has a significant relapse during delivery of services, referral to a treatment center may be appropriate. A directory of treatment centers in this state that report having some kind of special program for American Indians is provided (see Appendix C). Unfortunately we have not been able to check on all of these to make sure they are current and still have special programs for American Indians. We suggest that you telephone the treatment center and ask their staff questions based on the things that make effective treatment centers culture sensitive or syncretic before you make a judgment about which center to refer your client to. You might also ask them if they do anything to "Nativize" their treatment methods, such as using sweats, meditation, Medicine Wheels, or whatever might be appropriate for your client.

Determine Coexisting Disabilities

Alcoholism or substance abuse often coexists with other disabilities. Clients usually get referred for some other physical or mental disability. Problems with alcoholism or substance abuse might not be mentioned at all at referral, and may not be recognized until late in the rehabilitation process. Consequently, the presenting disability (disability at referral) often becomes identified as the primary disability, and the alcoholism or drug abuse, because they are identified later, may be considered secondary. However, surveys have indicated that almost 30% of the average counselor caseload had a primary or secondary disability of substance abuse. Failure to deal with a substance abuse problem can threaten and even sabotage the entire rehabilitation process (Corthell, 1991).

Transportation

In the AIRRTC's survey (Schacht & Gaseoma, 1997), counselors and clients both listed transportation as the main deterrent to successful rehabilitation. It would therefore be a good idea to find out if your client has difficulties with transportation; some assistance may be needed to help the client obtain suitable transportation. See Appendix D for informational materials that are in the training packet.

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Appendix A

The Twelve Steps of Alcoholics Anonymous

1 *We admitted we were powerless over alcohol — that our lives had become unmanageable.*

2 *Came to believe that a Power greater than ourselves could restore us to sanity.*

3 *Made a decision to turn our will and our lives over to the care of God as we understood him.*

4 *Made a searching and fearless moral inventory of ourselves.*

5 *Admitted to God, to ourselves and to another human being the exact nature of our wrongs.*

6 *We entirely ready to have God remove all these defects of character.*

7 *Humbly asked Him to remove our shortcomings.*

8 *Made a list of all persons we had harmed, and become willing to make amends to them all.*

9 *Made direct amends to such people wherever possible, except when to do so would injure them or others.*

10 *Continued to take personal inventory and when we were wrong promptly admitted it.*

11 *Sought through prayer and mediation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*

12 *Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.*

©Alcoholics Anonymous

Appendix B

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Rehabilitation Services Administration

VENDOR REQUEST FOR DOCUMENTATION OF "SUBSTANCE DEPENDENCE"

In order to establish eligibility for the services of Vocational Rehabilitation, the federal law requires that the existence of a mental or physical impairment be documented for each applicant.

In the case of Chemical Dependency, this documentation must be offered by a licensed physician, a certified or licensed psychologist, or by a State of Arizona Certified Substance Abuse Counselor *(certified by the Arizona Board of Behavioral Health Examiners).*

Eligibility requires a determination that the person is "Substance Dependent" under the criteria established in the DSM IV. **In order to satisfy the requirement for documentation, your report must include descriptive statements which illustrate the pattern of substance use upon which your diagnosis is based. In addition your report should include information regarding history of treatment and current treatment.**

A copy of the DSM IV criteria is on the reverse for your information.

Equal Opportunity Employer/Program
This document available in alternative formats by contacting your local RSA office.

DSM IV'S CRITERIA FOR "SUBSTANCE DEPENDENCE"

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three *(or more)* of the following, occurring at any time in the same 12-month period.

1. Tolerance, as defined by either of the following:

   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

   b. Markedly diminished effect with continued use of the same amount of substance.

2. Withdrawal, as manifested by either of the following:

   a. The characteristic withdrawal syndrome for the substance.

   b. The same *(or a closely related)* substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in large amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance *(e.g., visiting multiple doctors or driving long distances)*, use the substance *(e.g., chain smoking)*, or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of the substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance *(e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)*.

ARIZONA VR POLICIES RELATED TO CHEMICAL DEPENDENCY & ABUSE

(As of November, 1997)

DOCUMENTATION OF IMPAIRMENT

To diagnose chemical dependence, a diagnostic statement must be provided by: (a) a physician skilled in the diagnosis and treatment of mental or emotional disorders (psychiatrist), licensed by the state in which he/she practices; (b) a psychologist; licensed or certified by the state in which he/she practices; or (c) a State of Arizona Certified Substance Abuse Counselor, certified by the Arizona Board of Behavioral Health examiners.

(4-2-04 p. 24)

ELIGIBILITY

Issue: Documenting Ability to Benefit in Terms of an Employment Outcome"

NOTES: Although ability to benefit is generally assumed to exist, the counselor must explain whether there is/is not evidence to question that assumption: e.g. someone with a history of a serious drug abuse problem when there are indications that there is continued abuse to the extent that it interferes with ability to benefit. If there is, a decision must be made to place the individual in Extended Evaluation to provide clear and convincing evidence one way or the other. The counselor must address this issue in his/her narrative, if only to say that there is no reason to question the individual's ability to benefit.

(4-2-04 p. 33)

Whether or not someone is abusing drugs/alcohol is relevant to determining whether the individual can benefit from VR services in terms of an employment outcome. A client is assumed to be able to benefit unless there is clear and convincing evidence to the contrary. It is the responsibility of the counselor to use extended evaluation services to determine "ability to benefit" if there is a strong indication that the individual is abusing drugs/alcohol to an extent that vocational success is impossible or unlikely.

ARBITRARY PERIODS OF SOBRIETY CANNOT BE USED AS GENERAL STANDARDS FOR MAKING THE REQUIRED INDIVIDUALIZED VR ELIGIBILITY DETERMINATIONS.

Issue: What is the impairment?

It is the definition of "substance dependence" in the Diagnostic and Statistical Manual of Mental Disorders that can be considered a significant impairment which has the potential to interfere with an individual's employment and require VR services. A diagnosis of "substance abuse" alone cannot be used to determine VR eligibility (see "Documenting Substance Dependence".

To determine that an individual is "substance dependent" means that the individual meets the criteria of "Substance Dependent" as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). That definition describes a maladaptive pattern of substance use (see attached criteria).

The report used to describe "substance dependency" for eligibility purposes must include descriptive statements which illustrate the pattern of substance use and substance dependency (per the criteria in the DSM-IV) upon which the diagnosis is based. The report must also include information regarding the history of treatment and current treatment.

It is expected that counselors will make every attempt to obtain existing documentation of substance dependency. When requesting existing documentation or purchasing documentation, the counselor must send the Vendor Request for Documentation of "Substance Dependence" (VR-019) to the vendor which explains the type of documentation needed for eligibility purposes. When requesting an existing document, the appropriate client release of information form must be enclosed.

Issue: When does the individual require VR services?

Individuals who have marketable skills in occupations which pose no immediate and direct threat to continued sobriety and who require no other services would not normally be considered to require VR services to obtain/maintain gainful employment and would not be eligible. "Stress on the job" or "the job drives me to drink" are not unconditionally appropriate reasons for abandoning useable work skills.

Individuals with marketable skills may, however, require vocational counseling, job development and placement assistance, and other services related to their disability and resultant unemployment. Such individuals would be eligible for VR services but would not have access to training or education services.

(4-2-04 p. 39)

RESTORATION SERVICES

Detoxification is considered an acute medical service and is not provided by RSA. Alcohol or drug abuse maintenance programs are also not services provided by VR (they are considered medical care services, see DES4-2-07.C, Physical/Mental Restoration Services). Individuals are not eligible for VR based solely on the need for these services.

(4-2-04 p. 40)

Mental Health Treatment (0410816.10,11,12,30,40) means treatment of mental/psychological conditions through individual, family or group therapy. Services include: social work services, **substance abuse counseling**, mental health/substance abuse counseling.

(4-2-07 p. 25)

Appendix C

Prevention and Treatment Programs for Alcohol and Drug Abuse in Arizona: Programs with Special Services for American Indians/Alaska Natives

1. P.G.B.H.A B.H.A.C.A.
   Casa Grande Outpatient
   120 West Main Street
   Casa Grande, AZ 85222
   Phone: (602) 836-1688
   Prevention services and outpatient treatment for substance abuse (alcohol and other drugs).

2. Navajo Nation Dept. of Behavioral Health Services
   Twin Trails Treatment Center
   Navajo Route 7 East Of U.S. 191
   Chinle, AZ 86503
   Phone: (520) 674-5471
   Prevention services, outpatient treatment, and 24-hour residential treatment for substance abuse (alcohol, inhalants). Federally funded.

3. Native Americans For Community Action (NACA)
   Substance Abuse Services
   2717 North Steves Blvd., Suite 11
   Flagstaff, AZ 86004
   Phone: (520) 526-2968
   Prevention and other non-treatment services, and outpatient treatment for substance abuse (alcohol and other drugs). Federally funded.

4. Comcare
   Maverick House
   7022 North 48th Avenue
   Glendale, AZ 85301
   Phone: (602) 931-5810
   Hotline: (602) 640-9777 24 hours
   Non-treatment services, and 24-hour care detoxification for substance abuse (alcohol and other drugs).

5. Navajo Department of Behavioral Health Services
   Kayenta Department of Behavioral Health Services
   Kayenta, AZ 86033
   Phone: (520) 697-5570
   Prevention and other non-treatment services, and outpatient treatment for substance abuse (alcohol, inhalants). Federally funded.

6. Colorado River Indian Tribes
   Behavioral Health Services
   Route 1
   Parker, AZ 85344
   Phone: (520) 669-9211 x 415
   Outpatient, 24-hour care detoxification and residential treatment for substance abuse (alcohol and other drugs).

7. NW Organization for Voluntary Alternatives (NOVA)
   7725 North 43rd Avenue, Suite 522
   Phoenix, AZ 85051
   Phone: (602) 937-9203
   Hotline: (602) 640-9777 24 hours
   Non-treatment services and outpatient treatment for substance abuse (alcohol and other drugs).

8. Gila River Indian Community
   Alcohol And Drug Abuse Program
   Sacaton, AZ 85247
   Phone: (520) 562-3357
   Prevention and other non-treatment services, and outpatient treatment for substance abuse.

9. Cocopah Sovereign Nation
   Cocopah Alcohol and Drug Abuse Program
   Avenue G and County 15th
   Somerton, AZ 85350
   Phone: (520) 627-2161
   Prevention and other non-treatment services, and outpatient treatment for substance abuse (alcohol and other drugs). Federally funded.

10. Havasupai Health Center
    Havasupai Alcohol Program
    General Delivery
    IHS Clinic
    Supai, AZ 86435 2038
    Phone: (520) 448-2641
    Prevention and other non-treatment services, and outpatient treatment for alcohol abuse.

11. National Development/Research Inst.
    Desert Willow Program
    10755 East Tanque Verde Road
    Tucson, AZ 85749
    Phone: (602) 749-7122 x 306
    Substance abuse treatment services for alcohol and other drug abuse. Federally funded.

12. Rainbow Center
    White Mountain Apache Tribe
    Whiteriver, AZ 85941
    Phone: (520) 338-4858
    Prevention and other non-treatment services, 24-hour residential and outpatient treatment services for substance abuse (alcohol and other drugs).

Appendix D

THE VOCATIONAL REHABILITATION OF AMERICAN INDIANS WITH ALCOHOL ABUSE OR DEPENDENCY

American Indian Rehabilitation Research and Training Center
Northern Arizona University

November 19, 1997 - RSA Training Room, Phoenix, Arizona

Tentative Agenda

8:30–9:00	**Registration**
9:00–9:15	**Welcoming and Introductions** • Valerie Lintz, M.S., RSA Training Coordinator • Priscilla Sanderson (Navajo), CRC, Director, AIRRTC
9:15–10:00	**Research on American Indians with Alcohol Abuse or Dependency** • Robert M. Schacht, Ph.D., AIRRTC Research Director
10:00–10:15	Break
10:15–10:30	**Arizona VR Policies About Serving Clients with Alcohol Abuse or Dependency** • Valerie Lintz, M.S., RSA Training Coordinator
10:30–11:15	**Screening, Assessment and Treatment** • Timothy T. Thomason, Ed.D., Assistant Professor of Educational Psychology, Northern Arizona University
11:15–12:00	**Discussion**
12:00–1:00	**Lunch** (on your own)
1:00–2:00	**American Indian Cultural Issues Regarding Alcohol and Alcoholism** • Candice Shelton (Osage), Clinical Director, Guiding Star Lodge
2:00–3:00	**VR Strategies with American Indians with Alcohol Abuse or Dependency** • Robert M. Schacht, Ph.D., AIRRTC Research Director
3:00–3:15	Break
3:15–4:00	**Discussion**
4:00–4:15	**Wrap-up and Evaluation**

Recommended Reading on Alcoholism

Handbook of Differential Treatments for Addictions
L. L'Abate, J. Farrar, & D. Serritella

Handbook of Alcoholism Treatment Approaches
R. K. Hester & W. R. Miller

Practical Approaches to Alcoholism Psychotherapy
S. Zimberg, J. Wallace, & S. Blume

Alcoholism: A Guide to Diagnosis, Intervention, and Treatment
D. M. Gallant

Essentials Of Chemical Dependency Counseling
G. Lawson, D. Ellis, & P. C. Rivers

Substance Abuse Disorders in Clinical Practice
E. C. Senay

Heavy Drinking: The Myth of Alcoholism as a Disease
H. Fingarette

Treating Adolescent Substance Abuse
G. R. Ross

Working with the Problem Drinker: A Solution Focused Approach
I. K. Berg & S. D. Miller

Liberating Solutions to Alcohol Problems
D. Cameron

How to Quit Drinking Without AA
J. Dorsman

The Thinking Person's Guide to Sobriety
B. Pluymen

The Diseasing of America: Addiction Treatment Out of Control
S. Peele

The Truth About Addiction and Recovery
S. Peele & A. Brodsky

Native American Postcolonial Psychology
E. Duran & B. Duran

POST-TREATMENT INTERVIEW

Jerry Stubben

The Native American Substance Abuse Tribally Based Treatment Efficacy Study
Iowa State University
Center for Family Research
2625 N. Loop Dr., Suite 500
Ames, IA 50010

1. Did you complete treatment?
   If no, why?
   If yes, how has that changed your life?

2. Have you used alcohol or drugs since completing treatment?

3. What is your tribal affiliation? _____
   Are you enrolled?
   (Identify whether or not the Indian person is truly knowledgeable of their tribal culture, traditions, norms and values or is totally ignorant.)

   What American Indian cultural events do you attend?
   a) Attend Pow Wow's (as observer)
   b) Attend Pow Wow's (as dancer, sing at the drum, or other participant)
   c) Sweat Lodge
   d) Native American Church
   e) Learn stories and wisdom of Grandparents & other Tribal Elders
   f) Hunting (sober, Indian approach, with another Indian male)
   g) Use/learn Tribal Language
   h) Attend Sun Dance
   i) Feasts
   j) Other: _____

4. Where do you live?
   a) Halfway house
   b) on rez, or off
   c) with relatives who are sober
   d) with friends who are sober
   e) Other: _____

continued on back

5. Are you in a relationship with a significant other?
   a) If no, are you recently divorced, separated, widowed, etc.?
   b) If yes, is S.O. sober? Is your relationship supporting your recovery?

6. Employment: What is your current job situation? What are your employment goals?

7. Education: Do you have any plans re: Tribal College, GED, University.

8. Involvement in community events, feasts, honors, veterans groups, etc.

9. Arrests, run ins with law, courts: Have these problems gotten better or worse since treatment?

10. Are you seeking to be an active role model for youth?

11. Language: How do you view your tribal language now? Has your attitude towards it changed?

12. Drinking: After treatment, are you drinking more, drinking differently (e.g., social [moderate] drinking rather than binge drinking), or totally abstaining?

MAST – Michigan Alcohol Screening Test (Brief version)

Use: To assess adverse consequences of use–alcohol. The Brief MAST is reproduced in Alcohol- and Other Drug-Related Problems: Program and Curriculum.

Distributor: Dr. Melvin Selzer, 6967 Paseo Laredo, La Jolla, CA 92037 USA
Phone: (619) 459-1035

SCORING: A score of three points or less is considered non-alcoholic, four points is suggestive of alcoholism, a score of five points or more indicates alcoholism.

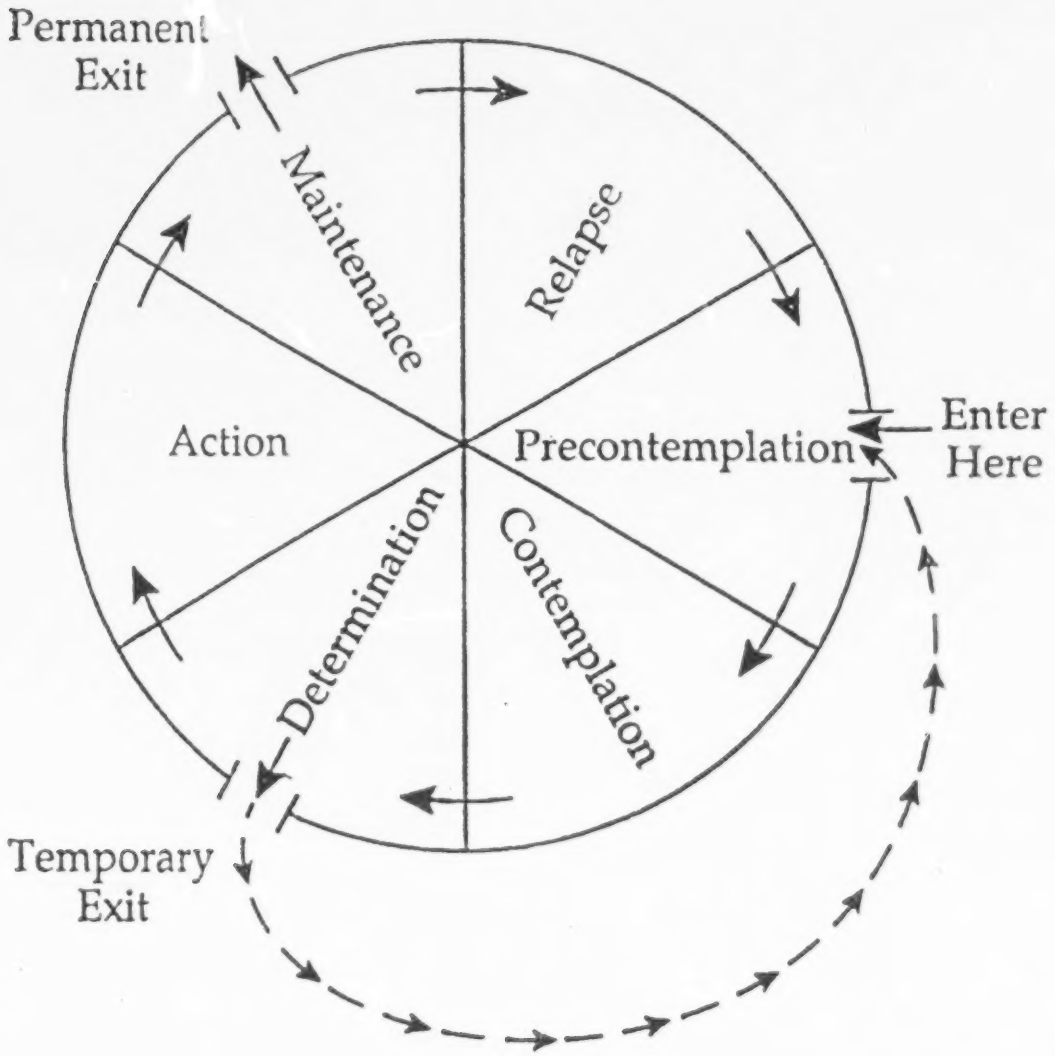
* Negative responses are alcoholic responses

Question Number	Points	Question
1	2	*Do you feel you are a normal drinker?
2	2	Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
3	1	Does your wife (husband, parents) ever worry or complain about your drinking?
4	2	*Can you stop drinking without a struggle after one or two drinks?
5	1	Do you ever feel bad about your drinking?
6	2	*Do friends or relatives think you are a normal drinker?
7	0	Do you ever try to limit your drinking to certain times of the day or to certain places?
8	2	*Are you always able to stop drinking when you want to?
9	5	Have you ever attended a meeting of AA?
10	1	Have you gotten into fights when drinking?
11	2	Has drinking ever created problems w/ you and your wife (husband)?
12	2	Has your wife (husband, family members) ever gone to anyone for help about your drinking?
13	2	Have you ever lost friends, girlfriends/boyfriends because of your drinking?
14	2	Have you ever gotten into trouble at work because of drinking?
15	2	Have you ever lost a job because of drinking?
16	2	Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?

continued on back

17	1	Do you ever drink before noon?
18	2	Have you ever been told you have liver trouble?
19	2	Have you ever had delirium tremens, severe shaking, heard voices, or seen things that weren't really there after heavy drinking?
20	5	Have you ever gone to anyone for help about your drinking?
21	5	Have you ever been hospitalized because of your drinking?
22	2	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?
23	2	Have you ever been seen at a mental health clinic (gone to a doctor, social worker, clergyman) for help with emotional problems in which drinking has played a part?
24	2	Have you ever been arrested, even for a few hours, because of drunk behavior?
25	2	Have you ever been arrested for drunk driving or driving after drinking?

Figure 5.1 A Stage Model of the Process of Change



Source: Adapted from James O. Prochaska and Carolo C. DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change." *Psychotherapy: Theory, Research, and Practice, 19:* 276–288. Reprinted with permission from W. R. Miller & K. A. Jackson (1985), *Practical Psychology for Pastors.* Englewood Cliffs, NJ: Prentice Hall, page 130.

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ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism
No. 30 -- PH 359 -- October 1995

Alcohol Alert, a publication of the National Institute on Alcohol Abuse and Alcoholism, provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the thirtieth in the series.

Diagnostic Criteria for Alcohol Abuse and Dependence

Diagnosis is the process of identifying and labeling specific conditions such as alcohol abuse or dependence (1). Diagnostic criteria for alcohol abuse and dependence reflect the consensus of researchers as to precisely which patterns of behavior or physiological characteristics constitute symptoms of these conditions (1). Diagnostic criteria allow clinicians to plan treatment and monitor treatment progress; make communication possible between clinicians and researchers; enable public health planners to ensure the availability of treatment facilities; help health care insurers to decide whether treatment will be reimbursed; and allow patients access to medical insurance coverage (1-3).

Diagnostic criteria for alcohol abuse and dependence have evolved over time. As new data become available, researchers revise the criteria to improve their reliability, validity, and precision (4,5). This *Alcohol Alert* traces the evolution of diagnostic criteria for alcohol abuse and dependence through the current standards of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (6). For comparison, the criteria found in the World Health Organization's International Classification of Diseases, Tenth Revision (ICD-10) also are reviewed briefly, although these are not often used in the United States (7).

Evolution of Diagnostic Criteria

Early Criteria

At least 39 diagnostic systems had been identified before 1940 (2). In 1941 Jellinek first published what is considered a groundbreaking theory of subtypes of what was, until 1980, termed alcoholism (2,8). Jellinek associated these subtypes with different degrees of physical, psychological, social, and occupational impairment (2,9). Formulations of diagnostic criteria continued with the American Psychiatric Association's publication of the Diagnostic and Statistical Manual of Mental Disorders, First Edition (DSM-I), and Second Edition (DSM-II) (10,11). Alcoholism was categorized in both editions as a subset of personality disorders, homosexuality, and neuroses (2,12).

In response to perceived deficiencies in DSM-I and DSM-II, the Feighner criteria were developed in the 1970's to establish a research base for the diagnostic criteria of alcoholism (5,13). These criteria were the first to be based on research rather than on subjective judgment and clinical experience alone (5). Though designed for use in clinical practice, they were primarily developed to stimulate continued research for the development of even more useful diagnostic criteria (5). Several years later, Edwards and Gross focused solely on alcohol dependence (8). They considered essential elements of dependence to be a narrowing of the drinking repertoire, drink-seeking behavior, tolerance, withdrawal, drinking to relieve or avoid withdrawal symptoms, subjective awareness of the compulsion to drink, and a return to drinking after a period of abstinence (8).

The DSM Criteria

Researchers and clinicians in the United States usually rely on the DSM diagnostic criteria. The evolution of diagnostic criteria for behavioral disorders involving alcohol reached a turning point in 1980 with the publication of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (14). In DSM-III, for the first time, the term alcoholism was dropped in favor of two distinct categories labeled alcohol abuse" and "alcohol dependence" (1,2,12,15). In a further break from the past, DSM-III included alcohol abuse and dependence in the category "substance use disorders" rather than as subsets of personality disorders (1,2,12).

The DSM was revised again in 1987 (DSM-III-R) (16). In DSM-III-R, the category of dependence was expanded to include some criteria that in DSM-III were considered symptoms of abuse. For example, the DSM-III-R described dependence as including both physiological symptoms, such as tolerance and withdrawal, and behavioral symptoms, such as impaired control over drinking (17). In DSM-III-R, abuse became a residual category for diagnosing those who never met the criteria

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for dependence, but who drank despite alcohol-related physical, social, psychological, or occupational problems, or who drank in dangerous situations, such as in conjunction with driving (17). According to Babor, this conceptualization allowed the clinician to classify meaningful aspects of a patient's behavior even when that behavior was not clearly associated with dependence (18).

The DSM was revised again in 1994 and was published as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (6). The section on substance-related disorders was revised in a coordinated effort involving a working group of researchers and clinicians as well as a multitude of advisers representing the fields of psychiatry, psychology, and the addictions (2). The latest edition of the DSM represents the culmination of their years of reviewing the literature; analyzing data sets, such as those collected during the Epidemiologic Catchment Area Study; conducting field trials of two potential versions of DSM-IV; communicating the results of these processes; and reaching consensus on the criteria to be included in the new edition (2,19).

DSM-IV, like its predecessors, includes nonoverlapping criteria for dependence and abuse. However, in a departure from earlier editions, DSM-IV provides for the subtyping of dependence based on the presence or absence of tolerance and withdrawal (6). The criteria for abuse in DSM-IV were expanded to include drinking despite recurrent social, interpersonal, and legal problems as a result of alcohol use (2,4). In addition, DSM-IV highlights the fact that symptoms of certain disorders, such as anxiety or depression, may be related to an individual's use of alcohol or other drugs (2).

The ICD Criteria

While the American psychiatric community was formulating its editions of diagnostic criteria for mental disorders, the World Health Organization was developing diagnostic criteria for the purpose of compiling statistics on all causes of death and illness, including those related to alcohol abuse or dependence, worldwide (1,4,20). These criteria are published as the International Classification of Diseases (ICD). The first ICD classification of substance-related problems, published in 1967 in ICD-8 (21), classified what was then called alcoholism with personality disorders and neuroses, as had DSM-I and DSM-II. In ICD-8, alcoholism was a separate category that included episodic excessive drinking, habitual excessive drinking, and alcohol addiction that was characterized by the compulsion to drink and by withdrawal symptoms when drinking was stopped (1).

Although ICD-9 (22,23) included separate criteria for alcohol abuse and dependence, this revision defined them similarly in terms of signs and symptoms (1). According to Babor, an important assumption in ICD-9 was that alcohol use in the absence of dependence "merits a separate category by virtue of its detrimental effects on health" (1, p. 87).

The category of alcohol dependence was central to the current revision, ICD-10 (1,2,7). Alcohol dependence is defined in this classification in a way that is similar to the DSM. The diagnosis focuses on an interrelated cluster of psychological symptoms, such as craving; physiological signs, such as tolerance and withdrawal; and behavioral indicators, such as the use of alcohol to relieve withdrawal discomfort (1). However, in a departure from the DSM, rather than include the category "alcohol abuse," ICD-10 includes the concept of "harmful use." This category was created so that health problems related to alcohol and other drug use would not be underreported (1). Harmful use implies alcohol use that causes either physical or mental damage in the absence of dependence (1).

Moving Toward Agreement Between Diagnostic Criteria

The DSM diagnostic criteria for psychiatric disorders are the criteria primarily used in the United States. The ICD is an international diagnostic and classification system for all causes of death and disability, including psychiatric disorders (4). Earlier editions of these two major diagnostic criteria dealing with alcohol abuse and dependence were criticized for being too dissimilar (2). Therefore, the DSM-IV and the ICD-10 were revised in a coordinated effort among researchers worldwide to develop criteria that were as consistent with one another as possible (1,2).

Although some differences between the two major diagnostic criteria still exist, they have been revised by consensus as to how alcohol abuse and dependence are best characterized for clinical purposes (18). Clinicians, international health agencies, and researchers are now better able to categorize people with alcohol dependence, abuse, and harmful use to plan treatment, collect statistical data, and communicate research results (18).

Diagnostic Criteria--A Commentary by NIAAA Director Enoch Gordis, M.D.

The research community has long found standardized diagnostic criteria useful. Such criteria provide agreement as to the constellation of symptoms that indicate the alcohol dependence syndrome and allow researchers all over the world to communicate clearly as to what kinds of disorders are being studied.

Standardized diagnostic criteria are equally important and useful to clinicians. In the alcohol field, there have been many

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different ways by which clinical staff might arrive at a diagnosis--sometimes differing among staff within the same program. Although the use of standard diagnostic criteria may seem somewhat burdensome, it provides many benefits: more efficient assessment and placement, more consistency in diagnoses between and within programs, enhanced ability to measure the effectiveness of a program, and provision of services to people who most need them. As we move more and more into a managed health care arena, third-party payors are requiring more standardized reporting of illnesses; they want to know what conditions they are paying for and that these conditions are the same from program to program. The standardized diagnostic criteria presented in this *Alert* are based on the newest research, have been developed based on field trials and extensive reviews of the literature, and are continually revised to reflect new findings. Although clinical judgment will always play a role in diagnosing any illness, alcohol treatment programs that use standardized diagnostic criteria will be in the best position to select appropriate treatment and to justify their selection to third-party payors.

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Table 1. DSM-III-R, DSM-IV, and ICD-10 Diagnostic Criteria for Alcohol Dependence *

None

	DSM-III-R	DSM-IV	ICD-10
Symptoms	A. At least three of the following:	A. A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress as manifested by three or more of the following occurring at any time in the same 12-month period:	A. Three or more of the following have been experienced or exhibited at some time during the previous year.
Tolerance	(1)Marked tolerance -- need for markedly increased amounts of alcohol (ie. at least 50 percent increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of alcohol	(1)Need for markedly increased amounts of alcohol to achieve intoxication or desired effect with continued use of the same amount of alcohol	(1)Evidence of tolerance, such that increased doses are required in order to achieve effects originally produced by lower doses
Withdrawal	(2)Characteristic withdrawal symptoms for alcohol (3)Alcohol often taken to relieve or avoid withdrawal symptoms	(2)The characteristic withdrawal syndrome for alcohol; or alcohol (or a closely related substance) is taken to relieve or avoid withdrawal symptoms	(2)A physiological withdrawal state when drinking has ceased or been reduced as evidenced by: the characteristic alcohol withdrawal syndrome, or use of alcohol (or a closely related substance) to relieve or avoid withdrawal symptoms
Impaired Control	(4)persistent desire or one or more unsuccessful efforts to cut down or control drinking. (5)Drinking in larger amounts or over a longer period than the person intended	(3)Persistent desire or one or more unsuccessful efforts to cut down or control drinking (4)Drinking in larger amounts or over a longer period than the person intended	(3)Difficulties in controlling drinking in terms of onset, termination, or levels of use.
Neglect of Activities	(6)Important social, occupational, or recreational activities given up or reduced because of drinking	(5)Important social, occupational, or recreational activities given up or reduced because of drinking	(4)Progressive neglect of alternative pleasures or interests in favor of drinking
Time Spent Drinking	(7)A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover from its effects	(6)A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover from its effects	A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover from its effects

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Inability to Fulfill Roles	(8)Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home, or	None	None
Hazardous Use	When drinking is physically hazardous	None	
Drinking Despite Problems	(9)Continued drinking despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by alcohol use	(7)Continued drinking despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by alcohol use	(5)Continued drinking despite clear evidence of overtly harmful physical or psychological consequences
Compulsive Use	None	None	(6)A strong desire or sense of compulsion to drink
Duration Criterion	B. Some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time	B. No duration criterion separately specified. However, three or more dependence criteria must be met within the same year and must occur repeatedly as specified by duration qualifiers associated with criteria (e.g., "often," "persistent," "continued")	B. No duration criterion separately specified. However, three or more dependence criteria must be met during the previous year.
Criterion for Subtyping Dependence	None	With psychological dependence: Evidence of tolerance or withdrawal (i.e., any of items A(1) or A(2) above are present) Without psychological dependence: No evidence of tolerance or withdrawal (i.e., none of items A(1) or A(2) above are present)	None

*The DSM-III-R, DSM-IV, and ICD-10 refer to substance dependence. These criteria have been adapted in this *Alcohol Alert* to focus solely on alcohol.

Table 2. DSM-III-R, DSM-IV, and ICD-10 Diagnostic Criteria for Alcohol Abuse/Harmful Use of Alcohol*

DSM-III-R Alcohol Abuse

A. A maladaptive pattern of alcohol use indicated by at least one of the following:
(1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of alcohol

(2) drinking in situations in which use is physically hazardous

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for alcohol dependence.

DSM-IV Alcohol Abuse

A. A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

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(2) recurrent drinking in situations in which it is physically hazardous

(3) recurrent alcohol-related legal problems

(4) continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol

B. The symptoms have never met the criteria for alcohol dependence.

ICD-10 Harmful Use of Alcohol

A. A pattern of alcohol use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

B. No concurrent diagnosis of the alcohol dependence syndrome.

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*The DSM-IIIR, DSM-IV, and ICD-10 refer to substance abuse and harmful use. These criteria have been adapted in this Alcohol Alert to focus solely on alcohol.

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